STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004444	A. BUILDING _____ B. WING _____	02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER HOUSE	2216 N RILEY HWY SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for State Residential Licensure Survey. Survey dates: January 31, February 1, 2, 2012 Facility number: 004444 Provider number: 004444 AIM number: N/A Survey team: Barbara Hughes, RN, TC Beth Walsh, RN Courtney, Mujic, RN (January 31, February 1, 2012) Karina Gates, BHS Census bed type: Residential: 10 Total: 10 Census payor type: Other: 10 Total: 10 Sample: 7 Walker House was found to be in compliance with 410 IAC 16.2 in regard to the State Residential Licensure Survey. Quality review completed 2/7/12 by Jennie Bartelt, RN.	R 000		